		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020297

Facility Name: Manorcare at Rolling Meadows

Address: 4225 Kirchoff Road (Number) | Rolling Meadows (City) | 60008 (Zip Code)

County: Cook

Telephone Number: (847) 397-2400 **Fax #** (847) 397-2414

HFS ID Number: 521077856001

Date of Initial License for Current Owners: 07/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/2004 to 05/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,353	9,596	10,172	42,121	8
9	SNF/PED					9
10	ICF	716			716	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,069	9,596	10,172	42,837	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.72%

D. How many bed-hold days during this year were paid by the Department?
2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 155 and days of care provided 7,932

Medicare Intermediary Care First of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	309,081	22,683	1,972	333,736	5,356	339,092		339,092			1
2	Food Purchase		213,220		213,220		213,220	(7,608)	205,612			2
3	Housekeeping	137,196	20,843	1,057	159,096		159,096		159,096			3
4	Laundry	52,890	12,530	1,400	66,820		66,820	(566)	66,254			4
5	Heat and Other Utilities			183,913	183,913	5,784	189,697	(9,470)	180,227			5
6	Maintenance	44,613	18,205	45,402	108,220		108,220		108,220			6
7	Other (specify):* **Med Waste**			1,154	1,154		1,154		1,154			7
8	**TOTAL General Services**	543,780	287,481	234,898	1,066,159	11,140	1,077,299	(17,644)	1,059,655			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	2,456,044	145,238	48,377	2,649,659	42,769	2,692,428	(302)	2,692,126			10
10a	Therapy	247,910	6,814	232,859	487,583		487,583		487,583			10a
11	Activities	113,506	4,569	2,610	120,685	470	121,155		121,155			11
12	Social Services	80,146		1,419	81,565		81,565		81,565			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,897,606	156,621	307,765	3,361,992	43,239	3,405,231	(302)	3,404,929			16
	C. General Administration											
17	Administrative	83,308		341,443	424,751	(113,100)	311,651		311,651			17
18	Directors Fees											18
19	Professional Services			5,172	5,172	(3,318)	1,854	(1,854)				19
20	Dues, Fees, Subscriptions & Promotions			52,400	52,400		52,400	(15,158)	37,242			20
21	Clerical & General Office Expenses	290,779	45,804	169,867	506,450		506,450	(136,550)	369,900			21
22	Employee Benefits & Payroll Taxes			717,161	717,161	39,320	756,481		756,481			22
23	Inservice Training & Education			4,770	4,770		4,770		4,770			23
24	Travel and Seminar			6,505	6,505		6,505		6,505			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			156,645	156,645		156,645		156,645			26
27	Other (specify):*											27
28	**TOTAL General Administration**	374,087	45,804	1,453,963	1,873,854	(77,098)	1,796,756	(153,562)	1,643,194			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,815,473	489,906	1,996,626	6,302,005	(22,719)	6,279,286	(171,508)	6,107,778			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Rolling Meadows #0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			302,835	302,835	17,101	319,936		319,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest					5,618	5,618	398	6,016			32
33	Real Estate Taxes			365,145	365,145		365,145	(71,897)	293,248			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,472	35,472		35,472		35,472			35
36	Other (specify):*											36
37	**TOTAL Ownership**			703,452	703,452	22,719	726,171	(71,499)	654,672			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		271,572	22,334	293,906		293,906	(1,698)	292,208			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			18,797	18,797		18,797		18,797			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,864	84,864		84,864		84,864			42
43	Other (specify):* **See Attached Schedule**			56,619	56,619		56,619		56,619			43
44	**TOTAL Special Cost Centers**		271,572	182,614	454,186		454,186	(1,698)	452,488			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,815,473	761,478	2,882,692	7,459,643		7,459,643	(244,705)	7,214,938			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,083)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,470)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	398	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(302)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,525)	2		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,854)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(136,050)	21		24
25	Fund Raising, Advertising and Promotional	(15,158)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(71,897)	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,764)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (244,705)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (244,705)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare at Rolling Meadows

ID# 0020297

Report Period Beginning: 06/01/2004

Ending: 05/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Ambulance Expense	$ (1,698)	38	1
2	Laundry Income	(566)	4	2
3	Admit Fees Other Income	(500)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,608)	0	0	0	0	0	0	0	0	0	0	(7,608)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(566)	0	0	0	0	0	0	0	0	0	0	(566)	4
5	Heat and Other Utilities	(9,470)	0	0	0	0	0	0	0	0	0	0	(9,470)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,644)	0	0	0	0	0	0	0	0	0	0	(17,644)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(302)	0	0	0	0	0	0	0	0	0	0	(302)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(302)	0	0	0	0	0	0	0	0	0	0	(302)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,854)	0	0	0	0	0	0	0	0	0	0	(1,854)	19
20	Fees, Subscriptions & Promotions	(15,158)	0	0	0	0	0	0	0	0	0	0	(15,158)	20
21	Clerical & General Office Expenses	(136,550)	0	0	0	0	0	0	0	0	0	0	(136,550)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(153,562)	0	0	0	0	0	0	0	0	0	0	(153,562)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(171,508)	0	0	0	0	0	0	0	0	0	0	(171,508)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Rolling Meadows** **#** **0020297** **Report Period Beginning:** **06/01/2004** **Ending:** **05/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	398	0	0	0	0	0	0	0	0	0	0	398	32
33	Real Estate Taxes	(71,897)	0	0	0	0	0	0	0	0	0	0	(71,897)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(71,499)	0	0	0	0	0	0	0	0	0	0	(71,499)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,698)	0	0	0	0	0	0	0	0	0	0	(1,698)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,698)	0	0	0	0	0	0	0	0	0	0	(1,698)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(244,705)	0	0	0	0	0	0	0	0	0	0	(244,705)	45

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corp.	Toledo, Ohio			
		of America				
		(SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See	Home Office Cost	$ 341,443	HCR ManorCare, Inc.	100.00%	$ 341,443	$	1
2	V		Page							2
3	V		8							3
4	V									4
5	V									5
6	V		10a	Therapy Management	19,098	Heartland Management Services	100.00%	19,098		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 360,541			$ 360,541	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 5/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit Street
City / State / Zip Code: Toledo, Ohio 43604
Phone Number: ((419) - 252-5500
Fax Number: ((419) - 252-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	$	$	6,800,124	$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	1,043,233	571,891	6,800,124	2,508	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	223,707		6,800,124	643	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,139,042		6,800,124	5,141	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	12,987,607	8,226,246	6,800,124	37,355	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,252,260	1,199,059	6,800,124	5,414	6
7	17	General & Administrative - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	16,611,639	15,056,893	6,800,124	47,779	7
8	17	General & Administrative - Poole	Accumulated Cost	2,829,104,777	369 Nurs Fac	75,121,310	43,509,256	6,800,124	180,564	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	3,924,545		6,800,124	11,288	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	11,662,215		6,800,124	28,032	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac			6,800,124	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	7,114,804		6,800,124	17,101	12
13										13
14	32	Interest				10,002,527			5,618	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 341,443	25

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5								Home Office Interest			5,618	5
	Working Capital											
6												6
7												7
8								Interest Expense			398	8
9	**TOTAL Facility Related**						$	$			$ 6,016	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$ 6,016	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Rolling Meadows **#** 0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 443,164	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 371,267	2
3. Under or (over) accrual (line 2 minus line 1).		$ (71,897)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 365,145	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 293,248	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	385,459	8
	2001	387,282	9
	2002	389,104	10
	2003	365,145	11
	2004	366,240	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Rolling Meadows COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0020297

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) - 252-5740 FAX #: (419) - 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-26-400-025-0000	See Attached	$ 182,572.63	$ 182,572.63
2.	02-26-400-025-0000	See Attached	$ 183,667.42	$ 183,667.42
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 366,240.05	$ 366,240.05

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,523 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 155,000	1
2					2
3	TOTALS			$ 155,000	3

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	$ 1,350,315	$ 51,357		$ 51,357	$	$ 1,230,402	4
5				1990	765,804						5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					167,994		167,994		1,562,243	9
10				1987	72,739						10
11	RETIREMENTS			1987	(44,531)						11
12				1988	33,303						12
13				1989	74,517						13
14				1990	157,389						14
15				1991	127,927						15
16				1992	107,998						16
17	RETIREMENTS			1992	(36,743)						17
18				1993	73,889						18
19				1994	71,280						19
20				1995	236,489						20
21	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1995	(791)						21
22	HVAC/DUCTWORK			1996	3,845						22
23	PLUMBING			1996	2,184						23
24	CORPORATE OVERHEAD-ARCADIA/DINING			1996	7,272						24
25	REMODEL ARCADIA/DINING/BEDROOM			1996	95,560						25
26	PROFESSIONAL FEES-ARCADIA/DINING			1996	1,737						26
27	CORNER GUARDS			1996	1,340						27
28	WOODEN DOORS			1996	11,077						28
29	WALLCOVERINGS			1996	5,279						29
30	ELECTRICAL/LIGHTING			1996	7,005						30
31	CARPETING			1996	3,300						31
32	REBUILD GENERATOR			1996	1,927						32
33	REPLACE SMOKE DETECTOR			1996	2,156						33
34	CR 5/31/99 AUDIT ADJ-CORPORATE O/H			1996	(7,272)						34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL HANDRAILS	1997	$ 8,660	$		$	$	$	37
38	WALL GUARDS	1997	2,756						38
39	REPLACE CEILING TILES	1997	12,173						39
40	REMOVE & INSTALL FIRE DOORS	1997	2,012						40
41	INSTALL CLOSET DOORS	1997	10,821						41
42	WALLCOVERINGS	1997	4,812						42
43	DECORATING	1997	10,594						43
44	CARPETING	1997	2,343						44
45	FLOORING	1997	11,254						45
46	REPAIR ELEVATOR	1997	3,430						46
47	ROOFING	1997	1,679						47
48	REMODELING-ARCADIA	1997	8,663						48
49	CONNECT WATER AND GAS LINES	1997	1,705						49
50	CORPORATE OVERHEAD-ARCADIA/DINING	1997	10,515						50
51	FACILITY PLAN ALLOC,-ARCADIA/DINING	1997	5,964						51
52	REPLACE CLOSET DOORS	1997	12,000						52
53	PROFESSIONAL FEES-ARCADIA/DINING	1997	1,396						53
54	CEILING TILES	1997	10,349						54
55	INSTALL CIRCULATING PUMPS	1997	2,250						55
56	BOILER WORK	1997	5,613						56
57	WALLPAPER	1997	482						57
58	STORAGE SHED	1997	789						58
59	REMODELING	1997	(8,489)						59
60	C/R 5/31/99 AUDIT ADJ. - CORPORATE O/H	1997	(10,515)						60
61	C/R 5/31/99 AUDIT ADJ. - FACILITY PLAN ALLOC	1997	(5,964)						61
62	ROOF WORK	1998	53,389						62
63	DOORS/WINDOWS	1998	10,090						63
64	PLUMBING	1998	3,838						64
65	RENOVATE PT & OT ROOMS	1998	4,500						65
66	DOOR & WINDOW CASINGS	1998	4,500						66
67	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,416						67
68	INSTALL STEEL DOORS	1998	4,224						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,315,244	$ 219,351		$ 219,351	$	$ 2,792,645	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,315,244	$ 219,351		$ 219,351	$	$ 2,792,645	1
2	ELECTRICAL	1998	754						2
3	PAINTING/WALLCOVERING	1998	36,239						3
4	PLUMBING	1998	13,534						4
5	ELECTRICAL	1998	10,004						5
6	DEVELOPERS-PT & OT ROOMS	1998	11,097						6
7	FLOORING/CEILING	1998	985						7
8	HVAC	1998	37,124						8
9	DOOR/WINDOW	1998	8,160						9
10	SIGN	1998	11,862						10
11	ROOFING	1998	92,520						11
12	MASONARY	1998	1,499						12
13	CARPENTRY	1998	1,475						13
14	FINISH STUDS	1998	26,279						14
15	GENERAL CONTRACTOR FEES-PT & OT ROOMS	1998	4,601						15
16	CONCRETE SIDEWALK	1998	1,482						16
17	FLOORING/CEILING	1999	1,340						17
18	CARPENTRY	1999	19,278						18
19	FINISH STUDS	1999	25,000						19
20	PAINTING/WALLCOVERING	1999	750						20
21	WINDOW TREATMENTS	1999	525						21
22	ROOF WORK	1999	6,098						22
23	C/R 5/31/03 AUDIT ADJ #1-ROOF WORK	1999	(6,098)						23
24	ROOFING CONTRACT	1999	876						24
25	C/R 5/31/03 AUDIT ADJ #2-ROOFING CONTRACT	1999	(876)						25
26	DRAIN/FLASH SCUPPERS/OVERFLOW	1999	1,782						26
27	ROOFING CONTRACT	1999	6,098						27
28	C/R 5/31/03 AUDIT ADJ #3-ROOFING CONTRACT	1999	(6,098)						28
29	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	4,554						29
30	BUILDING IMPROVEMENTS-NURSES STATIONS	1999	22,150						30
31	INSTALL CLOSETS	1999	2,895						31
32	25 EXIT SIGNS FOR BU	1999	4,810						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,655,943	$ 219,351		$ 219,351	$	$ 2,792,645	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,655,943	$ 219,351		$ 219,351	$	$ 2,792,645	1
2	VINYL WALLCOVERING	1999	336						2
3	WALLCOVERING	1999	226						3
4	RENOVATE NURSING STATIONS	1999	11,478						4
5	WALLCOVERING	1999	2,245						5
6	DAMPER MOTOR	1999	2,693						6
7	CHART RACK	2000	1,450						7
8	ELECTRICAL FOR A/C UNITS	2000	1,214						8
9	WALLCOVERING	2000	294						9
10	ELECTRICAL FOR A/C UNITS	2000	1,151						10
11	WORK STATIONS BOOKKEEPING & PAYROLL	2000	5,975						11
12	WORK STATIONS	2000	728						12
13	EXTERIOR LIGHTING	2000	19,956						13
14	CEILING TILE, PAINTING, CARPET	2000	900						14
15	FENCING	2000	17,820						15
16	FENCING	2000	1,980						16
17	CONCRETE, MASONRY, CARPENTRY	2000	49,335						17
18	CARPET	2000	35,925						18
19	C/R 5/31/03 AUDIT ADJ #4-CARPET	2000	(14,231)						19
20	WALLCOVERING	2000	52,636						20
21	C/R 5/31/03 AUDIT ADJ #5-WALLCOVERING	2000	(466)						21
22	ELECTRICAL	2000	34,947						22
23	C/R 5/31/03 AUDIT ADJ #6-ELECTRICAL	2000	(9,885)						23
24	INTEREST - CONST & GENERAL O/H ARCADIA	2000	74,862						24
25	C/R 5/31/03 AUDIT ADJ #15-CONST & GEN O/H	2000	(74,862)						25
26	ARCADIA RENOVATION	2000	12,075						26
27	C/R 5/31/03 AUDIT ADJ #10-ARCADIA RENOV	2000	(12,075)						27
28	ARCADIA RENO - DRAPES	2001	2,843						28
29	C/R 5/31/03 AUDIT ADJ #11-ARCADIA DRAPES	2001	(184)						29
30	ARCADIA RENO - CARPENTRY	2001	6,748						30
31	C/R 5/31/03 AUDIT ADJ #12-CARPENTRY	2001	(2,200)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,879,857	$ 219,351		$ 219,351	$	$ 2,792,645	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,879,857	$ 219,351		$ 219,351	$	$ 2,792,645	1
2	ARCAIDA RENO - CONTRACTOR	2001	50,636						2
3	C/R 5/31/03 AUDIT ADJ #13-CONTRACTOR	2001	(25,985)						3
4	ARCADIA RENO - ELECTRICAL	2001	3,560						4
5	BORDER	2001	170						5
6	KITCHEN WALLS AND FLOOR	2002	2,566						6
7	KITCHEN WALLS AND FLOOR	2002	14,796						7
8	DOORS	2002	6,445						8
9	DOORS	2002	1,868						9
10	DOORS	2002	7,740						10
11	PAINTING	2002	204						11
12	CEILING TILE	2002	517						12
13	DUCT WORK AND DAMPERS	2002	8,301						13
14	DOORS AND DRYWALL	2002	9,694						14
15	GENERAL CONSTRUCTION	2002	4,640						15
16	OVERHEAD AND INTEREST	2002	15,405						16
17	CARPENTRY	2002	85,703						17
18	C/R 5/31/03 AUDIT ADJ #7-CARPENTRY	2002	(650)						18
19	VINYL WALL COVERING	2002	10,495						19
20	C/R 5/31/03 AUDIT ADJ #8-VINYL WALL COVERING	2002	(979)						20
21	HVAC, ELECTRIC	2002	12,530						21
22	C/R 5/31/03 AUDIT ADJ #9-RECLASS HVAC, ELECTRIC	2002	(4,808)						22
23	PARKING LOT UPGRADE	2002	17,482						23
24	PARKING LOT UPGRADE	2003	1,943						24
25	METAL DOOR	2003	1,968						25
26	WALLCOVERINGS	2003	563						26
27	CARPET	2003	335						27
28	FLOORING & CARPENTRY	2003	100,275						28
29	CARPENTRY	2003	27,714						29
30	DOORS AND FRAMES	2003	24,849						30
31	SPRINKLER SYSTEM	2003	9,660						31
32	DOORS	2004	4,464						32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,271,957	$ 219,351		$ 219,351	$	$ 2,792,645	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,271,957	$ 219,351		$ 219,351	$	$ 2,792,645	1
2	HERITAGE WING ROOF	2004	10,976						2
3	HERITAGE WING	2004	10,976						3
4	VWC	2004	291						4
5	VWC	2004	203						5
6	CARPET	2004	659						6
7	FREIGHT ON CARPET	2004	37						7
8	CARPET & BASE	2004	674						8
9	FREIGHT ON CARPET	2004	109						9
10	CARPET	2004	5,250						10
11	COVE BASE	2004	3,545						11
12	INSTALL CARPET	2004	4,222						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,308,899	$ 219,351		$ 219,351	$	$ 2,792,645	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,241,056	$ 83,484	$ 83,484	$		$ 891,788	71
72	Current Year Purchases	74,938						72
73	Fully Depreciated Assets							73
74				17,101	17,101			74
75	TOTALS	$ 1,315,994	$ 83,484	$ 100,585	$ 17,101		$ 891,788	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,779,893	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 302,835	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 319,936	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,101	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,684,433	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 35,472 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3242	hrs	$ 94,130	3,222	$ 80,541	$ 522	6,464	$ 175,193	1
2	Licensed Speech and Language Development Therapist	10a	913	hrs	26,514	1,644	41,101	180	2,557	67,795	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4382	hrs	127,266	4,449	111,217	6,112	8,831	244,595	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39, 2		# of prescrpts				271,572		271,572	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S X-Ray & Lab	39,3					22,334			22,334	13
14	TOTAL				$ 247,910	9,315	$ 255,193	$ 278,386	17,852	$ 781,489	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Rolling Meadows **#** 0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,521	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (48,490))	1,316,148		3
4	Supply Inventory (priced at)	39,012		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,918		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,379,599	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	155,000		13
14	Buildings, at Historical Cost	4,308,899		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,315,994		16
17	Accumulated Depreciation (book methods)	(3,684,433)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,095,460	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,475,059	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,576	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	446,221		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	365,145		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	71,830		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 970,772	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	52,186		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 52,186	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,022,958	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,452,101	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,475,059	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,110,557	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,110,557	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	568,399	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 568,399	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(226,855)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (226,855)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,452,101	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,824,131	1
2	Discounts and Allowances for all Levels	(1,502,022)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,322,109	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,439,570	6
7	Oxygen	(1,956)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,437,614	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	836	12
13	Barber and Beauty Care	22,349	13
14	Non-Patient Meals	1,249	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	239,675	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	44	19
20	Radiology and X-Ray	3,018	20
21	Other Medical Services	980	21
22	Laundry	566	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 268,717	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(363)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (363)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(35)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (35)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,028,042	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,066,159	31
32	Health Care	3,361,992	32
33	General Administration	1,873,854	33
	B. Capital Expense		
34	Ownership	703,452	34
	C. Ancillary Expense		
35	Special Cost Centers	454,186	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,459,643	40
41	**Income before Income Taxes (line 30 minus line 40)****	568,399	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 568,399	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,957	2,139	$ 73,396	$ 34.31	1
2	Assistant Director of Nursing	1,987	2,171	61,902	28.51	2
3	Registered Nurses	25,127	27,462	740,561	26.97	3
4	Licensed Practical Nurses	16,861	18,428	441,991	23.98	4
5	CNAs & Orderlies	78,158	85,418	1,116,845	13.08	5
6	CNA Trainees					6
7	Licensed Therapist	6,158	6,703	194,634	29.04	7
8	Rehab/Therapy Aides	2,563	2,790	53,276	19.10	8
9	Activity Director					9
10	Activity Assistants	8,562	9,351	113,506	12.14	10
11	Social Service Workers	4,264	4,652	80,146	17.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,435	26,714	309,081	11.57	15
16	Dishwashers					16
17	Maintenance Workers	2,154	2,319	44,613	19.24	17
18	Housekeepers	12,225	13,336	137,196	10.29	18
19	Laundry	5,684	6,208	52,890	8.52	19
20	Administrator	2,006	2,006	83,308	41.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,152	16,716	290,779	17.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,398	1,526	21,349	13.99	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	208,691	227,939	$ 3,815,473 *	$ 16.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	22,500	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,906	5,10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,406		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Smelser	Administrator	0	$ 25,218
Lynette M. Rugg	Administrator	0	58,090
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,308

B. Administrative - Other

Description	Amount
Home Office	$ 341,443
TOTAL (agree to Schedule V, line 17, col. 3)	$ 341,443
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand & Elvidge Kelley	Legal	$ 405
Foote, Meyers, Mielke, & Flowers	Legal	1,449
Roche Dietitians, LLC	Special Cons	2,848
Quality Care Consulting Svs.	Special Cons	470
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,283
Unemployment Compensation Insurance	51,479
FICA Taxes	276,233
Employee Health Insurance	248,885
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	5,651
401K	25,977
Other Employee Benefits	(1,744)
Tuit Pgrm & SMSPMatch	2,198
Employee Uniforms	198
Home Office Allocation	39,320
P/R O/H	1
TOTAL (agree to Schedule V, line 22, col.8)	$ 756,481

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,312
Advertising: Employee Recruitment	4,781
Health Care Worker Background Check	10,819
(Indicate # of checks performed 98)	1,181
Dues & Subscriptions	809
Association Dues	4,951
Advertising	23,932
Public Relations	1,615
Less: Lobbying Expense	(1,598)
Less: Public Relations Expense	(1,615)
Non-allowable advertising	(11,945)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,242

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,505
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meetings.	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,505

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Rolling Meadows # 0020297 Report Period Beginning: 06/01/2004 Ending: 05/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Rolling Meadows **#** 0020297 **Report Period Beginning:** 06/01/2004 **Ending:** 05/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,951**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $1,598**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,648** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **84,864**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(1,249)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.